FEW/142/06.

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

ENID SPURGIN

Volume 1

Main file

Confidential information
Case summary
Expert witness reports
Suspect interviews

12

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Devine, Cunningham and Lake
7. Generic Case File further evidence - interviews with Dr Reid
8. Devine Volume 1
9. Devine Volume 2
10. Devine Additional Evidence
11. Devine Hospital Medical Records
12. Spurgin Volume 1
13. Spurgin Volume 2
14. Spurgin - further evidence
15. Spurgin - further evidence
16. Spurgin Hospital Medical Records
17. Spurgin Hospital Medical Records
18. Cunningham Volume 1
19. Cunningham Volume 2
20. Cunningham Hospital Medical Records
21. Cunningham Hospital Medical Records
22. Packman Volume 1
23. Packman Volume 2
24. Packman - further evidence
25. Packman police interviews with Dr Reid
26. Packman Hospital Medical Records
27. Lake Volume 1

28. Lake Volume 2
29. Lake Hospital Medical Records
30. Lake Hospital Medical Records
31. Service Volume 1
32. Service Volume 2
33. Service Hospital Medical Records
34. Service Hospital Medical Records
35. Gregory Volume 1
36. Gregory Volume 2
37. Gregory Hospital Medical Records
38. Gregory Hospital Medical Records
39. Wilson Volume 1
40. Wilson Volume 2
41. Wilson Hospital Medical Records
42. Wilson Hospital Medical Records
43. Lavender Volume 1
44. Lavender Volume 2
45. Lavender Hospital Medical Records
46. Lavender Hospital Medical Records
47. Lavender Hospital Medical Records
48. Pittock Volume 1
49. Pittock Volume 2
50. Pittock Hospital Medical Records
51. Further evidence re: Wilson, Lavender & Pittock
52. GP Records for Spurgin, Pittock, Service, and packman
53. GP Records for Devine, Cunningham and Lavender
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Richards (Eversheds) file: 1 of 2
57. Richards (Eversheds) file: 2 of 2
58. Richards: Medical Records
59. Richards: Further Medical Records
60. Richards: Further Medical Records
61. Richards (Police) - Witness Statements file
62. Richards (Police) - Transcripts of Interviews file
63. Page (Experts' Reports and Medical Records)
64. Wilkie (Eversheds) file: Experts' Reports and Medical Records
65. Clinical Team Assessments for Page, Cunningham, Wilkie, Wilson and Richards.
66. Clinical Team Assessments for Devine, Gregory, Lavender, Packman, Spurgin, Lake and Pittock

Operation ROCHESTER.

Key points June 2006.

Enid Dormer SPURGIN Born 16th February 1907.

Enid SPURGIN married at the age of 26years and ran a market garden in the Meon Valley Hampshire with her husband Ronald until he died in 1958. The couple were childless.

Her nephew describes her as a fit and healthy and active woman all of her life, she was tall of slim build and driving a car until she was 90.

At the time of her death in 1999 she was 92 years of age.

She had previously suffered a stress fracture of the right hip in 1981. In 1988 she was noted to have Pagets disease in her pelvis and suffered a probable Myocardial Infarction in 1989.

In 1997 she was seen by Dr MEARS a Consultant Psycho-Geriatrician for depression, he also noted poor eyesight. She was showing signs of memory impairment.

Otherwise Mrs SPURGIN was a relatively fit and independent widow living alone.

On the 19th March 1999 she suffered a fall whilst walking her dog fracturing her right hip.

She was admitted to Haslar Hospital where her hip was surgically repaired using a dynamic hip screw.

Within hours of the surgery there followed the complication of leakage from the wound causing her right thigh to swell to twice its normal size.

It was considered that she had probably developed a haematoma due to a bleeding vessel in the wound.

Post operatively Mrs SPURGIN was mobilised from a bed to a chair and walked by nurses small distances with a zimmer frame.

She was incontinent at night and had a small sore on the back of her right leg.

She was given pain relief, paracetamol as required.

On 26th March 1999 Mrs SPURGIN was transferred to Dryad ward at Gosport War Memorial Hospital. A single page medical note records that she had a history of fractured neck of the femur and no significant past history. She was not 'weight bearing' she was not continent. The medical plan was to 'sort out analgesia'.

Nursing notes refer to pain, the first night she had difficulty in moving and was given Oramorphine.

On the 27th March she was receiving regular Oramorphine but was still in pain.

On the 28th March the nursing notes comment that Mrs SPURGIN had been vomiting with Oramorph and that Dr BARTON had advised to stop the Oramorph and try Metoclopramide three times a day and co-dydramol.

On 29th March pain needed to be reviewed.

On 31st March 10mgs of morphine slow release tablets were administered. He is noted to have walked with a physiotherapist but remained in a lot of pain which remained between the 1st and 3rd of April.

On the 4th April it was noted that the wound was oozing serious fluid and blood.

On 7th April Mrs SPURGIN was seen by Dr BARTON, who thought the wound site was infected and prescribed antibiotics.

On the 7th April 1999 a medical note comments that Mrs SPURGIN was 'still in a lot of pain and very apprehensive'. The note suggested X ray of the right hip as movement was still quite painful.

On the 8th April the morphine slow release tablets are increased to 20mgs as required. It is documented that Mrs SPURGIN should remain bed rested until Dr REID had reviewed the X ray of her hip.

Mrs SPURGIN deteriorates on 11th April, nursing notes record that she is very drowsy and refusing food and drink. The wound looks red and inflamed and feels hot.

Following discussion with Dr BARTON a decision is made to commence a syringe driver.

The patient is seen by Dr REID who reduces the level of diamorphine.

On the 12th April diamorphine is written up 20-100mgs. 80mgs was started in a syringe driver at 0800hrs and was discarded at 1640hrs when the dosage was reduced by Dr REID to 40mgs in 24hrs. 20mgs of Midazolam was also placed in the syringe driver at 0800hrs.

On the 12th April the notes record that she was now very drowsy and not rousable. Diamorphine was reduced from 60mg's to 40mg's with a note to increase to 60mgs if pain recurs.

At 1.15am on 13th April it is noted that Mrs SPURGIN died peacefully.

Clinical team assessment.

5. Enid SPURGIN.92. Died 12th April 1999 eighteen days after admission to Gosport War memorial hospital. She had suffered a fractured hip which had been repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief.

Pain became an issue as soon as she arrived at Dryad. Analgesia was started with Oramorph regularly and then regular co-dydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain.

Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 mg a day. It had to be reduced, because she was too drowsy and it probably contributed to her death.

No evidence of consultation with appropriate specialist over the management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

Dr Jane BARTON from Caution interview with police 15th September 2005.

Within a prepared statement Dr BARTON commented that upon Mrs SPURGINS transfer to Dryad Ward on 26th March 1999 her right lower leg was very swollen and had a small break on the posterior aspect. She needed encouragement with eating and drinking but could manage independently.

Her only medication at that time was paracetamol as required.

Dr BARTON admitted Mrs SPURGIN to the ward making a brief admission note.

She believes that she was concerned to reassess her wound and ensure that she should have adequate analgesia. Swabs were taken all being negative for MRSA.

It was noted that Mrs SPURGIN was experiencing pain, she prescribed Oramorph and Lactulose.

On 27th March Dr BARTON increased the Oramorph dose concerned that the previous dose had not been adequate in relieving pain.

Dr BARTON was subsequently contacted by nursing staff, she believes she was informed that Mrs SPURGIN had been vomiting with the Oramorph. Accordingly it was discontinued and Co - Dydramol commenced.

Further negative tests were made for infection.

Dr BARTON believes she again reviewed Mrs SPURGIN on 31st March when she prescribed Morphine Sulphate as a consequence of inadequate pain relief of Co-Dyrdramol. Oramorph was given simulataneously.

By 6th April Dr BARTON had increased the Morphine Suphate dosage to 20mgs twice a day, concerned that she was developing an infection from an oozing wound, she subsequently prescribed antibiotics.

Dr REID saw the patient on 7th April confirming the fact that Morphine Sulphate had been increased and prescribing a minor anti-depressant. He requested an X ray of the hip. Dr BARTON is unable to say what the x ray demonstrated as there is no report available.

It appeared that Mrs SPURGINS condition deteriorated over the weekend 10th/11th April and it appears a discussion took place between the nephew and nursing staff with the nephew recorded as having been anxious that Mrs SPURGIN should be kept as comfortable as possible.

There follows an entry on the nursing record suggesting that Mrs SPURGIN was seen by Doctor BARTON probably the morning of 12th April 1999. In view of her condition and deterioration Dr BARTON prescribed Diamorphine and Midazolam to provide relief from pain and distress to be administered by syringe driver.

The doses were commenced at 80mg Diamorphine and 20mgs Midazolam at 0900hrs on 12th April 1999.

Dr BARTON anticipates that the doses were discussed with her.

Dr REID carried a ward round later that afternoon and reduced the dose of diamorphine to 40mgs noting that it should be increased to 60mg if pain recurred, by then approximately 25mgs of diamorphine would have administered from Dr BARTONS prescription.

At no time was the medication provided with the intention of hastening Mrs SPURGIN's demise.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology comments:-

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999.

Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999.

Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of expert orthopaedic surgeon raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam was in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented.

Mrs Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/ toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist.

Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin

unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture.

The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor both in terms of mortality or morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

A significant problem in Mrs Spurgins case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, '(GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include – taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

There are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport, the failure to address the cause of this lady's pain or to consider any other actions from 26th March until 7th April, the use of Oramorphine on a regular

basis from admission without considering other possible analgesic regimes.

Subsequent management of Mrs Spurgin's pain was within current practice with the exception of the starting dose of Diamorphine (80mg in the syringe drive is at best poor clinical judgement). However, the expert was unable to satisfy beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Expert Consultant Orthopaedic Surgeon Dr Daniel REDFERN comments:-

Mrs Spurgin suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate.

The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Evidence of other key witnesses.

Carl JEWELL Nephew, background in respect of deceased. Visited Aunt at Haslar hospital impressed by level of care, Mrs SPURGIN seemed OK in herself and was lucid.

Visited aunt four or five times after transfer to Gosport War memorial hospital. She seemed fine.

Visited Aunt on 12th April 1999 she was unconscious and unrousable. Dr REID told him that she was on too high a dose of morphine. Doctor told nurse to reduce aunts diamorphine, he said she would be alright.

Received call at 0130hrs 13th April and informed that she had died.

Helen McCORMACK(formerly Helen MEARS) Psychiatric Consultant saw Mrs SPURGIN on 11th November 1997 depressed and becoming increasingly frail, intellectual and with it but did not want to socialise. Failing eyesight and

hearing she would rather be dead than carry on like this. She has a one eyed rescue greyhound that she walks 3 times a day. Provides detailed background.
As a result wrote to Mrs SPURGINS GP Dr TAYLOR on 12th November 1997.

Fraser HARBAN Senior house officer anaesthetics Royal Hospital Haslar. Explains his detailed handwritten note re anaesthetic post op 20th March 1999.

Ian GURNEY Pre registration house officer Royal Hospital Haslar. ON 24TH March wrote that patient would benefit from Dr LORD for rehabilitation commenting ' she was previously well with no significant past medical history, living alone and independently with no social service input. She was transfused with three pints of blood but has otherwise made an unremarkable post op recovery. She has proved quite difficult to get mobilised and her post op rehabilitation may prove somewhat difficult...

Gill RANKIN Army nursing officer in charge Orthopaedic ward, Royal Hospital Haslar. On 26th March 1999 wrote Mrs SPURGINS transfer letter to Dryad ward.

Gillian HAMBLIN Clinical manager (Senior sister) Dryad Ward. Describes ward routines. Was the nursing manager for Mrs SPURGIN in charge of all aspects of patient care with the exception of drug prescription. Lynne BARRATT was the named nurse but junior to Mrs HAMBLIN. Mrs HAMBLIN never administered drugs to this patient, but as senior sister it was her duty to ensure that drugs were given appropriately.

Lynne BARRETT Staff nurse Dryad Ward. Reviews and explains medical notes and nursing care afforded to Mrs SPURGIN. Morphine sulphate tablets given to Mrs SPURGIN twice daily between 31st March and 11th April 1999. On 12th March at 0900hrs 60mgs of diamorphine reduced to 40mg at 1640hrs the same day. Does not know why Dr BARTON started the dose at 60mg.

Freda SHAW Staff nurse Dryad Ward. Explains her entries on nursing notes. Administered Morphine sulphate on four occasions between 31st March and 8th April 1999. Administered 80mgs of Diamorphine and 20mgs of Midazolam at 0900rs on 12th April 1999.

Susan NELSON Staff nurse covering Dryad Ward on nights. Noted that Mrs SPURGIN had a poor night on 10th April 1999 and administered Oramorph on 11th April.

Fiona WALKER Night clinical manager (sister) Gosport War Memorial Hospital. Comments upon hospital routine. At 0115am 13th April 1999 she verified death. She wrote 'Died peacefully death confirmed by night sister Fiona WALKER in the presence of Staff Nurse Siobhan COLLINS'

Siobhan COLLINS Staff nurse. As above+ comments upon training administration drugs and explains nursing note entries 11th -13th April 1999.

Irene DORRINGTON Staff nurse. Witnessed various drug administration to Mrs SPURGIN.

Beverly TURNBULL Staff nurse. Details concerns around use of syringe drivers. Witnessed Oramorph administered to Mrs SPURGIN 26th and 27th March1999.

Anita TUBRITT Senior Staff nurse. Administered Oramorph to Mrs SPURGIN on three occasions.

Ingrid LLOYD Staff nurse. Details drugs administered to Mrs SPURGIN.

Shirley DUNLEAVY Senior Physiotherapist Gosport War Memorial Hospital. Explains physio note of 1st April 1999.

Detective Constables YATES and QUADE.
Conducted tape recorded interviews with Dr BARTON on 15th September 2005 she produced a prepared statement.

Code A

D.M.WILLIAMS
Detective Superintendent 7227.
8th June 2006.

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.

Police officer witness statements
Transcript suspect interviews

SUMMARY OF EVIDENCE

CASE OF ENID SPURGIN

Background/Family Observations

Enid Dormer SPURGIN was born on Code A She had one brother who died aged 76 years from a stroke. She married at about the age of 26 but had no children. They ran a market garden in Meon, Hampshire until 1958 when her husband died. Mrs SPURGIN sold the business and moved to Gosport where she lived alone until her death at the Gosport War Memorial Hospital on 13th April 1999 aged 92 years.

Mrs SPURGIN was a fit, healthy and active person who was still driving a car at 90 years of age.

In the late 80's she was admitted to QA Hospital with Ryan's disease where she stayed for three weeks. Shortly after leaving the hospital she was again driving and walking her dogs. She appeared not to suffer from the ill effects of leaving hospital.

Mrs SPURGIN was very independent who was always able to hold a conversation with you and was fully aware of her surroundings. She did have help around the home but was adamant that she wished to remain there and would not have a live in companion.

On 19th March 1999 Mrs SPURGIN fell outside the Post Office in Stubbington and was admitted to Haslar Hospital where she had an operation on her right hip. Although in pain the physiotherapists got her sitting up and moving. She was okay in her self and still lucid when she spoke.

On 26th March 1999 Mrs SPURGIN was transferred to the Gosport War Memorial Hospital, Dryad Ward from where she was expected to return home. Whilst at Gosport War Memorial Hospital Mrs SPURGIN seemed fine but stated she rarely saw any doctors or physiotherapists. When the staff were spoken to about this they stated that she was too uncomfortable to be moved and had told the staff to go away on several occasions. In a letter from Mrs SPURGIN's financial advisor on the 9th April he stated that Mrs SPURGIN was terribly depressed and had not seen a doctor.

On 12th April 1999 Mrs SPURGIN when visited by relatives was found to be unconscious and unable to be roused when spoken to by a doctor. The doctor stated that there was nothing wrong with Mrs SPURGIN but she was on a too higher dose of morphine. At 1800 hrs she was still heavily sedated. At 2200 hrs a relative received a call from staff at Gosport War Memorial Hospital who said Mrs SPURGIN was conscious and had taken sips of water.

On 13th April 1999 at 0130 hrs staff again called this time to say that Mrs SPURGIN had died.

Her death certificate was signed by Dr BARTON and the cause was given as cerebralvascular accident.

Mrs SPURGIN was cremated at Portchester Crematorium.

Mrs SPURGIN received a lack of treatment and care whilst at Gosport War Memorial Hospital and was somewhat abandoned, there are also concerns regarding the level of morphine she was prescribed.

Medical history of Enid SPURGIN.

At the time of her death in 1999 Edith SPURGIN was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. She was also noted to have Paget's disease in her pelvis in 1988. She had a probably myocardial infarction in 1989. In 1997 she had been seen by a Dr Mears, a Consultant Psycho-Geriatrician, for depression. He also noted poor eyesight. At that time she was on an anti-depressant and was noted to have a normal minim-mental test score of 27/30 . She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment.

Enid SPURGIN was admitted to the Haslar Hospital on the 19th March 1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999. Post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn.

The next medical notes we have until her death, are written on a single page from Gosport Hospital. This states that the patient was transferred to Dryad Ward on 26th March, with a history of a fractured neck of femur and no significant past medical history. The medical notes state she was not weight bearing, she was not continent, her skin was tissue paper like. The medical plan was "sort out analgesia".

The next medical note is on the 7th April, "still in a lot of pain and very apprehensive. MST increased to 20 mgs bd yesterday, try adding Flupenthixol. For x-ray of right hip as movement still quite painful – also about 2" shortening right leg."

The next medical note is 12th April, "now very drowsy (since Diamorphine infusion established) reduced to 40 mgs per 24 hours, if pain recurs increase to 60mgs". Able to move hips (illegible) pain, patient not rousable. Final note is dated 1.15 am 13th April. Died peacefully.

Nursing notes from Mrs SPURGIN's admission on 26th March continually refer to pain. The first night she has difficulty in moving, Oramorphine is given. The admission care plan mentions she was experiencing a lot of pain on movement. The desired outcome is "to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation". 27th March, "is having regular Oramorphine but still in pain". 28th March "has been vomiting with Oramorph, advised by Dr BARTON to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

On 29th pain needed to be reviewed and on 31st March 10 mgs bd of MST (Morphine slow release tablets) is documented. "Mrs SPURGIN walked with the Physiotherapist but was in a lot of pain". She was still having pain on 1st and 3rd April.

On 4th April it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr BARTON who thought the wound site was infected and started Mrs SPURGIN on Metronidazole and Ciprofloxacin (both antibiotics). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr Reed had reviewed the x-ray of the hip.

Mrs SPURGIN clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink. The wound looks red and inflamed and feels hot. After discussion with Dr BARTON, a decision is made to commence a syringe driver.

The patient is seen by Dr Reed Diamorphine is reduced. On the early morning of 13th April, death is confirmed.

Dependency is also confirmed by a Waterlow score of 32 on the 26th March (i.e. very high risk for pressure sores) and a Barthel of 6/20 on 29th March and 5/20 on 10th April.

Drug management in Gosport and the use of analgesia:

At the point of admission Oramorphine 10 mgs in 5 mls (2.5 – 5 mgs 4 hourly prn) is written up on the "as required" part of the drug chart. A few doses are documented to have been given on 31st March – 11th April.

On the regular prescription Oramorphine 2.5 mgs 4 hourly and 5 mgs at night is written up, first dose given by 10 am on 26th March. This is then changed to 5 mgs four hourly with 10 mgs at night up until 28th March, then the Oramorphine is then discontinued and Co-dydramol 2 tablets 6 hourly written and prescribed from 28th March – 1st April (125).

Metoclopramide 10 mgs three times a day is written up continuously from 28th March to 11th April, but is only actually given to the patient intermittently. Morphine slow release tablets 10 mgs bd (MST) are written up on 31st March and given to 6th April. MST 20 mgs bd is written up on 6th April and given to 11th April.

Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given to 11th April. (134)

Finally, Diamorphine 20 – 100 mgs is written up on 12th April. 80 mgs in a syringe driver started at 8 am and according to the drug chart "dose is discarded at 16.40 hours and reduced the dosage to 40 mgs in 24 hours". The pump is discontinued at 1.30 am on the patients death on 13th April. Midazolam 20 – 80 mgs is written and is prescribed. 20 mgs put in the syringe driver at 8 am. It appears this was increased to 40 mgs at 16.40 hours and discontinued at 1.30 am on 13th April.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Enid SPURGIN was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr BARTON to Mrs SPURGIN following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr Robert BLACK in his review of Dr BARTON's care reported specifically:-

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, or consider any other action from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Dr Andrew WILCOCK reports:-

i) The notes relating to Mrs SPURGIN's transfer to Dryad Ward are inadequate. On admission, a patient is usually clerked highlighting in particular the relevant history, examination findings, planned investigations and care plan.

ii) There was insufficient assessment and documentation of Mrs SPURGIN's pain and its treatment.

iii) An orthopaedic opinion was not sought even when the pain did not improve with time or increasing doses of morphine that were associated with undesirable effects.

iv)An appropriate medical assessment was not undertaken when Mrs SPURGIN deteriorated, becoming more drowsy and her wound more painful and inflamed.

v) Doses of diamorphine and midazolam that were excessive to her needs were administered.

He further states;-

Mrs SPURGIN was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs SPURGIN's hip/thigh on movement continued to be a problem noted by Dr REID when he reviewed Mrs SPURGIN on the 24th March 1999. Surgeon Commander SCOTT reviewed Mrs SPURGIN but no specific comment was recorded in the medical notes regarding Mrs SPURGIN's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs SPURGIN in Haslar Hospital, the report of Mr REDFERN raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr BARTON and Dr REID was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs SPURGIN's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam in doses excessive to Mrs SPURGIN's needs.

When Mrs SPURGIN became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented. Mrs SPURGIN was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist. Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr REID, as a result of finding Mrs SPURGIN unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr BARTON in particular, but also Dr REID, could be seen as doctors who breached the duty of care they owed to Mrs SPURGIN by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs SPURGIN by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr BARTON and Dr REID exposed Mrs SPURGIN to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr BARTON and Dr REID leave themselves open to the accusation of gross negligence.

Interview of Dr Jane BARTON.

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took

up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 15th September 2005 Dr BARTON in company with her solicitor Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Enid SPURGIN at the Gosport War Memorial Hospital. The interviewing officers were DC YATES and DC QUADE.

The interview commenced at 0916hrs and lasted for 28 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/9. This statement dealt with the specific issues surrounding the care and treatment of Enid SPURGIN.

The expert response to the statement of Dr BARTON from Dr WILCOCK is:-

Dr BARTON admits to poor note keeping. However, even with episodes considered potentially serious and significant by Dr BARTON, no entry was made in the medical notes, even on a weekend when Dr BARTON was not presumably time pressured to the same extent. Having read Dr BARTON's statement regarding Enid SPURGIN, I believe the following issues raised remain valid and have not yet been satisfactorily addressed, for example:

- there was insufficient assessment of Mrs SPURGIN's pain on admission to Dryad Ward
- contrary to the usual expectation that pain would reduce post-operatively, the pain continued, even when the dose of morphine was increased to a dose associated with undesirable effects; despite this there was insufficient assessment of the possible causes of Mrs SPURGIN's pain and no orthopaedic review was obtained
- there was a lack of a thorough medical assessment when Mrs SPURGIN's condition deteriorated
- an inappropriate dose of diamorphine was used in a syringe driver
- although the dose of diamorphine was subsequently reduced, the dose of midazolam was increased.

In short, Dr BARTON in particular, but also Dr REID, could be seen as doctors who breached the duty of care they owed to Mrs SPURGIN by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs SPURGIN by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain and when her physical state deteriorated in what was possibly a temporary and reversible way. Instead the actions of Dr BARTON and Dr REID exposed Mrs SPURGIN to the inappropriate use of doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr BARTON and Dr REID leave themselves open to the accusation of gross negligence.

Furthermore a Consultant Orthopaedic and Tramua Surgeon Dr Daniel REDFEARN reports:-

Mrs SPURGIN suffered a relatively complex hip fracture as a result of her fall on March 19 1999. The decision to operate and the implants and operative technique employed were

appropriate. I am unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings

She had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at. Gosport War Memorial Hospital Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

2

DRAFT REPORT

regarding

ENID SPURGIN (BJC/45)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

2. INSTRUCTIONS

3. ISSUES

4. BRIEF CURRICULUM VITAE

5. DOCUMENTATION

6. CHRONOLOGY/CASE ABSTRACT

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

8. OPINION

9. LITERATURE/REFERENCES

10. EXPERTS' DECLARATION

11. STATEMENT OF TRUTH

1. SUMMARY OF CONCLUSIONS

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of Mr Redfern raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented. Mrs Spurgin was

not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist. Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

3.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Code A

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Enid Spurgin, including the medical certificate of cause of death.

[2] Full set of medical records of Enid Spurgin on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Hampshire Constabulary Summary of Care of Enid Spurgin.

[6] Palliative Care Handbook Guidelines on Clinical Management, Third

Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[7] Portsmouth Health Care NHS Trust Policies:

i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).

ii) Prescription Writing Policy (July 2000).

iii) Policy for Assessment and Management of Pain (May 2001).

iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).

v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).

vi) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

[8] General Medical Council, Good Medical Practice (July 1998).

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (September 1998).

[10] British National Formulary (BNF). Section on Prescribing in the Elderly (September 1998).

[11] Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (undated).

[12] Statement of Dr Jane Barton RE. Enid Spurgin, 15th September 2005.

[13] Draft Report regarding Statement of Dr Jane Barton RE. Enid Spurgin (BJC/45), Dr A Wilcock, 5th January 2006.

[14] Draft overview of Enid Spurgin (BJC/45), Dr A Wilcock, 1st November 2005.

[15] Draft Report regarding Enid Spurgin, Mr D R M Redfern, 22nd January 2006.

6. CHRONOLOGY/CASE ABSTRACT

Events at Royal Haslar Hospital, 19th–26th March 1999

Mrs Spurgin, a 92 year old widow who lived alone, was admitted on the 19th March 1999 to Haslar Hospital having been pulled over by her dog onto her right hip resulting in a fracture (page 66 of 135).

Mrs Spurgin was considered 'basically well with no major medical problems' (page 68 of 135). Most of her past medical history was orthopaedic with fractures of her right patella, sternum (page 13 of 135), fifth metacarpal of her right hand (page 86 of 135), stress fracture left hip (page 37 of 51), crush fractures lumbar spine vertebrae (page 38 of 51), lumbar back ache, right hip pain, Pagets disease of the sacrum and right ilium, stress fracture right hip (page 44 of 51); a probable inferior myocardial infarction in 1989 (page 6 of 51), depression secondary to failing physical health in 1997 (page 171 of 175) and removal of a cataract in 1998 (page 153 of 175).

Mrs Spurgin's fracture was repaired surgically using a dynamic hip screw on the afternoon of the 20th March 1999 (page 75 of 135). Mrs Spurgin's pre-operative care raised concerns for the anaesthetist who reviewed her at 12.00h on the 20th March 1999 (page 68 of 135). On admission, she had been made 'nil by mouth' as she was possibly going to theatre the same day (page 68 of 135). This did not occur, but she remained nil by mouth and no intravenous fluids were administered. As a result Mrs Spurgin was likely to be dehydrated; she had not taken any fluid in nor passed urine for over 24h. The anaesthetist was also concerned Mrs Spurgin had received minimal analgesia and in addition to intravenous

fluids gave her morphine 2mg IV. On review 2h later the anaesthetist noted that Mrs Spurgin had passed urine, but also that she had hallucinated following the morphine (page 69 of 135). An outline of the sequence of events that led to Mrs Spurgin receiving inadequate fluid pre-operatively was given by Dr Woods (the SHO) later in the notes (page 80 of 135).

Mrs Spurgin's post-operative course was not straight forward. A review at 21.30h on the 20th March 1999 noted '+++ooze' (i.e. leakage) from the wound but only 40ml in the wound drain (page 69 of 135). Mrs Spurgin complained of discomfort in the leg and pain on palpation and her right thigh was noted to be twice the size of her left. It was considered most likely she had developed a haematoma. This is a collection of blood due to bleeding into the operation site. As the amount increases, the greater the swelling and, if in an enclosed space, the greater the pressure it exerts. The increasing pressure can lead to a compartment syndrome compressing blood vessels and damaging surrounding tissue and nerves (see technical issues). The reviewing doctor examined Mrs Spurgin with this in mind, noting two collections underneath the wound and checking the circulation and nerve function in the leg, which appeared to be satisfactory (page 79 of 135). The clinical impression formed by the doctor was that Mrs Spurgin may have a potential bleeding vessel in the wound (to explain why her leg had become rapidly so swollen), and that she was at risk of compartment syndrome (due to increasing pressure from the haematoma) and hypovolaemia (low blood volume; due to bleeding into the wound)(page 79 of 135). Mrs Spurgin's haemoglobin was reduced at 82g/L (normal range 105–160g/L), having being 122g/L on the day of admission

(page 67 of 135) which suggests she had lost a significant amount of blood as a result of the fracture, its repair and the bleed into the wound. Subsequently, Mrs Spurgin received a three unit blood transfusion on the 21st March 1999 which corrected her anaemia (haemoglobin 111g/L on 22nd March 1999; page 92 of 135).

On the 21st March 1999 concerns remained about Mrs Spurgin's hydration level due to her poor urine output. Her blood tests suggested that she was dehydrated (urea 13.3mmol/L, creatinine 136micromol/L; normal range 3.2–7.5 and 71–133 respectively; page 90 of 135). Her right hip was noted to be painful+++ and her thigh enlarged but there was no ooze from the wound (page 82 of 135). The nursing notes reported that Mrs Spurgin had a lot of pain on movement with a plan to give morphine before moving her (page 27 of 135).

On the 22nd and the 24th March 1999 Mrs Spurgin was reviewed on the wardround by Surgeon Commander Scott, whom I presume was the consultant responsible for her care. There was no specific mention of her painful swollen right thigh, but she was referred to Dr Lord for rehabilitation and a referral letter written in the notes (pages 82, 83 and 84 of 135). This noted that Mrs Spurgin was transfused with three units of blood, but 'has otherwise made a remarkable post-op recovery.' There is no mention of the haematoma, but it does go on to state '...she has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. Additionally the quality of her skin, especially her lower legs is poor and at great risk of breaking down....' (page 83, 84 of 135). On the 23rd March 1999, the nursing notes reported that Mrs Spurgin had difficulty and pain++ with mobility (page 25 of 135).

Mrs Spurgin was reviewed by Dr Reid on the 24th March 1999 (pages 11 and 84 of 135). Dr Reid notes that Mrs Spurgin was '...previously well, but still in a lot of pain which is the main barrier to her mobilisation at present' and asked that her analgesia be reviewed. Dr Reid stated that he would be happy to take Mrs Spurgin to Gosport War Memorial Hospital provided that the orthopaedic team was satisfied that 'orthopaedically all is well with the right hip' (page 84 of 135). In his formal letter that followed, Dr Reid reported that prior to the fall Mrs Spurgin was 'very active and in good health' and repeated his concerns regarding Mrs Spurgin's hip, noting that 'the main problem was pain and swelling of the right thigh. Even a limited range of passive movement was painful. I was concerned about this and I would like to be reassured that all is well from an orthopaedic point of view' (page 11 of 135).

Surgeon Commander Scott reviewed Mrs Spurgin again on the 25th March 1999. It was noted that her right leg was increasingly swollen and that a haematoma had developed and broken down. It is unclear if 'broken down' relates to her wound breaking down as a result of the haematoma but dressing with jelonet and elevation were recommended (page 85 of 135). Commander Surgeon Scott considered that Mrs Spurgin could go to Gosport War Memorial Hospital but to warn them that her skin required great care (page 85 of 135). The nursing notes reported that Mrs Spurgin had had a settled evening and mobilised to the commode with two staff. Mrs Spurgin was transferred the following day on the 26th March 1999 (pages 25 and 26 of 135).

Mrs Spurgin's analgesia consisted of morphine and paracetamol p.r.n. 'as required'; she received morphine 5mg IM at 19.15h and 23.00h on the 20th

March 1999 and at 11.15h on the 21st March 1999 (page 38 of 135). Paracetamol 1G was taken on the following dates (number of doses): 19th (one); 21st (two), 22nd (two), 24th (one) and 25th March 1999 (one) (page 38 of 135).

Events at Dryad Ward, 26th March 1999 until 13th April 1999.

26th March 1999

The nursing transfer note written by Royal Haslar Hospital for Dryad Ward noted that Mrs Spurgin was mobile from bed to chair with two nurses and could walk short distances with a zimmer frame; she was continent during the day but occasionally incontinent at night; the skin on her lower legs was paper thin; her right lower leg was very swollen and needed elevating and there was a small break on the posterior aspect that had been steri-stripped. She needed encouragement with eating and drinking but could manage independently. No drugs were included as she was only on paracetamol p.r.n. 'as required' (page 20 of 175).

The medical note entry reports Mrs Spurgin's fracture of the right femur on the 19th March 1999, nil of significance in her past medical history and that she was non-weight bearing, had tissue paper skin and was not continent. The plan was to 'sort out her analgesia' (page 24 of 175).

The drug chart reveals that Mrs Spurgin was prescribed oral morphine (Oramorph) 5–10mg p.r.n. and also regularly: 5mg every 4h (at 06.00, 10.00, 14.00, 18.00h) and 10mg at 22.00h along with lactulose (a laxative) 10ml twice a day (pages 123 and 125 of 175).

Blood tests were undertaken which revealed a mild anaemia (haemoglobin 10.1g/dL; page 46 of 175) and elevated urea of 9.5mmol/L (normal 3.0–

7.6mmol/L; page 40 of 175). Swabs from her nose, throat, axillae, groins and wound, probably as a routine, were taken to screen for Methicillin resistant staphylococcus aureus (MRSA) and were all negative (pages 32 and 58 of 175).

The nursing summary notes record that Mrs Spurgin had been admitted 'for rehabilitation and gentle mobilisation.' Despite the information in the transfer letter from Haslar Hospital, on Dryad Ward her transferring had been difficult; Mrs Spurgin had complained of a lot of pain for which she was given oral morphine regularly 'with effect' (page 106 of 175). Her 'very dry tissue paper skin' in the lower legs, the small break on back of right calf, and her swollen legs were noted (page 106 of 175). A nursing care plan for Mrs Spurgin's wounds, specifies only that her right leg was swollen and oedematous (page 88 of 175). A handling profile reported pain in the right hip (page 102 of 175).

A nursing care plan was produced for 'Enid is experiencing a lot of pain on movement' and listed the nursing action as 'give prescribed analgesia and monitor effect; position comfortably and seek advice from physiotherapists regarding moving and mobilising' (page 84 of 175).

The nursing care plan for 'Enid requires assistance for settling for the night' noted that she used the slipper bed pan but had difficulty in moving; slept for long periods; Oramorph given as boarded for pain in hip' (pages 80 and 81 of 175).

The nursing summary for the night reported 'requires much assistance with mobility at present due to pain/discomfort. Oramorph 10mg given 23.15h and 5mg at 06.00h' (page 106 of 175).

27th March 1999

The nursing notes reported that it required two nurses to transfer Mrs Spurgin (page 114 of 175) and despite regular Oramorph, Mrs Spurgin was still in pain (page 84 of 175).

The drug chart shows that the regular oral morphine was increased to 10mg every 4h (at 06.00, 10.00, 14.00, 18.00h) and 20mg at 22.00h (page 125 of 175).

28th March 1999

The nursing notes reported that Mrs Spurgin had been vomiting with the Oramorph. Dr Barton advised to stop the Oramorph and Mrs Spurgin received metoclopramide (an anti-emetic) and codydramol for pain relief instead (pages 84 and 85 of 175).

The drug chart shows that the last oral morphine dose was at 10.00h and that codydramol 2 tablets 4 times a day (a total of dihydrocodeine 80mg and paracetamol 4G/24h) were commenced at 18.00h and taken regularly until the 31st April 1999 (page 125 of 175). Metoclopramide (an anti-emetic) 10mg three times a day was also commenced and taken intermittently until the 11th April 1999 (page 134 of 175).

29th March 1999

The nursing notes recorded a request for Mrs Spurgin's analgesia to be reviewed (page 85 of 175) and a mobility evaluation indicated that she required two nurses to move around the bed, a hoist to get in and out of bed and was unable to walk (page 103 of 175).

The drug chart shows that senna (a laxative) 2 tablets at night were commenced and taken until the 10th April 1999 (page 134 of 175).

30th March 1999

The nursing notes record that the steristrips on Mrs Spurgin's surgery wound were removed. A dressing was applied to one small area near top that was oozing slightly (page 89 of 175).

31st March 1999

The nursing notes record that Mrs Spurgin was commenced on modified release morphine (MST) 10mg twice a day. She walked with the physiotherapist in the morning but was in a lot of pain (page 85 of 175). Oramorph 5mg was given for pain relief at 13.15h with 'not too much effect' (pages 85 and 123 of 175). Mrs Spurgin slept well (page 81 of 175). The drug chart records the commencement of MST 10mg twice a day until the 6th April 1999 (page 134 of 175).

1st April 1999

The nursing notes record that Mrs Spurgin was seen by the physiotherapist and that the recommendation was that she remain on her bed rather than in a chair over the Easter holiday but to walk with a zimmer frame once or twice a day (page 85 of 175). The physiotherapy report specifies that Mrs Spurgin should walk twice a day with a gutter frame (page 96 of 175). Mrs Spurgin was noted to have pain on movement (page 85 of 175). Her right hip wound was 'oozing large amounts of serous fluid

and some blood' from a hole in the wound 1–1.5cm long. This was steristripped but continued to ooze (page 81 of 175).

2nd April 1999

The nursing notes record that a different type of dressing (Granuflex) was applied to the wound on Mrs Spurgin's right calf as her leg was oedematous (swollen) (page 89 of 175).

3rd April 1999

The nursing notes record that the MST 10mg twice a day continued and that Mrs Spurgin continued to complain of pain on movement (page 85 of 175).

4th April 1999

A nursing care plan was commenced for Mrs Spurgin's right hip wound 'oozing serous fluid and blood. Steristrip in-situ at present' (pages 86 and 87 of 175). On the same day, the dressings were renewed, no new leakage was seen, the steristrip was intact and a dry dressing reapplied (page 87 of 175).

6th April 1999

The nursing notes record that swabs to test for the presence of infection were taken from the from right hip and right calf wounds. The dressing was removed off the hip wound and left uncovered. The calf wound was leaking and redressed (page 87 of 175). Subsequently, the calf wound cultured the bacterium staphylococcus aureus, sensitive to the antibiotics

erythromycin, flucloxacillin and penicillin. This result was available on the 9th April 1999 (page 52 of 175).

The nursing summary notes record that Mrs Spurgin was seen by Dr Barton and that the MST was increased to 20mg (page 106 of 175). Mrs Spurgin's nephew visited who offered to employ a live-in carer for when she was discharged home (as she was adamant about not going to a nursing home). Mrs Spurgin had been incontinent of urine a few times and the use of a catheter discussed (pages 106 and 107 of 175).

The drug chart shows the increase in the MST to 20mg twice a day which continued until 20.00h on the 11th April 1999 (page 134 of 175).

7th April 1999

The nursing notes reported that Mrs Spurgin's hip wound was red and inflamed and she was seen by Dr Barton and commenced on antibiotics (metronidazole 400mg and ciprofloxacin 500mg both twice a day)(pages 89 and 107 of 175). She was later reviewed by Dr Reid who noted that Mrs Spurgin was still in a lot of pain and very apprehensive. Her MST had been increased to 20mg twice a day yesterday. He prescribed flupenthixol and requested an X-ray of the right hip to be done, as movement was still quite painful and the right leg was 2 inches shorter than the left (page 24 of 175).

The drug chart shows prescriptions for a five day course of antibiotics (ciprofloxacin and metronidazole; page 134 of 175) and the flupenthixol 0.5mg twice a day, given until the 11th April 1999 (page 8 of 175).

8th April 1999

The nursing notes reported that Mrs Spurgin's wound was oozing slightly overnight but that the redness at the edges of the wound was subsiding (page 87 of 175).

9th April 1999

The nursing notes reported that Mrs Spurgin was to remain on bed rest until Dr Reid saw the X-ray of her hip (page 85 of 175). It was noted that Mrs Spurgin had spilt two drinks in bed and had had a nightmare early morning (page 81 of 175). Because of episodes of urinary incontinence and being 'very distressed when put on to commode earlier today' Mrs Spurgin agreed to have a catheter inserted at 19.30h which drained 500ml overnight (page 115 of 175).

10th April 1999

The nursing notes reported that the catheter was draining 'concentrated urine – small amount. Enid not drinking despite encouragement and help'. Mrs Spurgin spilt her drink prior to settling and had a 'very poor night (page 81 of 175).

11th April 1999

The nursing notes recorded that Mrs Spurgin 'appears to be leaning to the left. Does not appear to be as well and experiencing difficulty in swallowing. Stitch line inflamed and hard area. Complaining of pain on movement and around stitch line. Oramorph 5mg given at 07.15h' (pages 81, 85 and 123 of 175). Other entries report 'commenced antibiotics a few

days ago, wound not leaking today but hip feels hot and Enid complaining of tenderness all around site. Enid very drowsy and irritable' (page 87 of 175); 'Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods' (page 83 of 175). A bladder washout was performed due to leakage (I assume bypassing) of dark concentrated urine. It was flushed without problem and 'very little drainage' was noted at 17.00h (page 115 of 175).

The nursing summary notes record that Mrs Spurgin's nephew was telephoned at 19.10h as Enid's condition had deteriorated over the afternoon; '....She is very (the nurse's emphasis) drowsy - unrousable at times. Refusing food and drink and asking to be left alone. Site around wound in right hip looks red and inflamed and feels hot. Asked about her pain, Enid denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that Enid be kept as comfortable as possible. He will telephone ward later this evening. Seen by Dr Barton to commence syringe driver' (page 107 of 175). However, in her statement, Dr Barton believes this last point refers to her seeing Mrs Spurgin on the morning of 12th April 1999.

12th April 1999

The nursing notes reported that Mrs Spurgin's condition 'remains ill. Urine very concentrated. Syringe driver satisfactory. Appears to be in some discomfort when attended to. Breathing very shallow' (page 83 of 175).

Mrs Spurgin was seen by Dr Reid who made an entry into the medical notes 'now very drowsy (since diamorphine infusion established) – reduce

to 40mg/24h – if pain recurs increase to 60mg. Able to move hip without pain but patient not rousable!' (Dr Reid's emphasis)(page 24 of 175).

The nursing summary notes also recorded the decisions taken on the wardround and that Mrs Spurgin's nephew had been spoken to and was aware of the situation (page 108 of 175).

The drug chart shows that Mrs Spurgin was prescribed, on the regular prescription part of the drug chart, diamorphine 20–200mg, midazolam 20–80mg, hyoscine (hydrobromide) 200–800microgram (marked p.r.n. in the margin) and cyclizine (an anti-emetic) 50–100mg (marked p.r.n. in the margin) all SC/24h (page 131 of 175). A syringe driver was commenced at 08.00h containing diamorphine 80mg/24h and midazolam 20mg/24h (page 131 of 175). It was altered at 16.40h to one containing a reduced dose of diamorphine 40mg/24h and an increased dose of midazolam 40mg/24h (page 131 of 175).

13th April 1999

An entry was made at 01.15h confirming that Mrs Spurgin had died (pages 24 and 83 of 175).

On the death certificate, the cause of death was given as 1a Cerebrovascular accident, with an onset of 48h prior to death.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF number 36 (September 1998)). Others sometimes suggest dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a breakthrough dose would be 5mg. One would expect it to have a 2–4h duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients' symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (September 1998) recommends 20–100mg SC over 24h. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24h if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, and it may need to be given more frequently. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has anti-emetic, antispasmodic (smooth muscle colic) and sedative properties.

Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400microgram SC over 24h (BNF (September 1998)) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram over 24h.

The titration of the dose of analgesic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses needed over a 24h period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional 'as required' doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the use of 1–2 'as required' doses over a 24h period is generally seen as acceptable.

ii) The principle of double effect

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When

correctly used (i.e. in a dose *appropriate* to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

iii) Compartment syndrome.

See also the report by Mr Redfern.

Thick layers of tissue called fascia separate groups of muscles in the leg into different compartments. There is limited scope for expansion within a compartment, and a significant swelling, such as a large haematoma, will lead to an increase in pressure, compressing the surrounding muscles, blood vessels and nerves. If the pressure builds sufficiently, the blood flow to the tissues is reduced and this can lead to permanent injury to the muscle and nerves. The hallmark symptom of compartment syndrome is severe pain that does not respond to elevation or pain medication. There may also be:

- tense, swollen and shiny skin overlying the limb
- severe pain when the muscle is moved actively or passively
- pain when the compartment is squeezed.

In more advanced cases, there may be:

- decreased sensation

- muscle weakness
- pallor of the skin.

8. OPINION

Events at Royal Haslar Hospital, 19th–26th March 1999

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. She underwent surgical repair of a fractured right hip using a dynamic hip screw. Mrs Spurgin's post-operative course was not straight forward; within hours of her surgery she had to be reviewed because of leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. A large haematoma can exert a pressure effect, compressing blood vessels and damaging surrounding tissue and nerves. The reviewing doctor appropriately examined Mrs Spurgin with this in mind, checking the circulation and nervous function in her leg, which appeared satisfactory. Pain in Mrs Spurgin's hip/thigh on movement continued to be recorded as a problem in the nursing notes and by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. He considered the pain the main barrier to rehabilitation, asked for her analgesia to be reviewed and to be reassured that orthopaedically all was well with her hip. Surgeon Commander Scott reviewed Mrs Spurgin several times between the 22nd–25th March 1999 but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia but on the 25th March she was considered able to be transferred to Gosport War Memorial Hospital once a bed was available. Despite pain

being recorded as a problem, at no point did Mrs Spurgin receive regular analgesia; three doses of morphine given as required within the first 24h of her surgery and subsequently, only paracetamol as required, at most 2G in 24h. One explanation for this apparent discrepancy would be that Mrs Spurgin was relatively comfortable at rest and only experiencing significant pain on movement and/or weight bearing.

With regards to the standard of care proferred to Mrs Spurgin during her admission to Haslar Hospital, I am not experienced enough in orthopaedics to comment, but the report of Mr Redfern raises several concerns.

Events at Dryad Ward, 26th March 1999 until 13th April 1999.

Infrequent entries in the medical notes during Mrs Spurgin's stay on Dryad Ward make it difficult to closely follow her progress over the last eighteen days of her life. There are three entries prior to the confirmation of death, taking up one page in length. In summary and approximate chronological order, Mrs Spurgin was admitted to Dryad Ward for rehabilitation and gentle mobilisation. It was noted that Mrs Spurgin complained of a lot of pain on movement for which she was commenced on regular oral morphine. Despite this there was no mention of pain nor a formal pain assessment in the medical clerking. Mrs Spurgin initially was prescribed a total of 30mg/24h of oral morphine regularly. This was increased the next day to 60mg/24h and was the probable cause of her nausea and vomiting. The response to Mrs Spurgin's vomiting appears nonsensical; if it were that her pain was considered severe enough to warrant morphine regularly, the addition of a regular anti-emetic would be seen as an appropriate response. Instead the morphine was substituted for the weaker

analgesic codydramol. Because of continued pain on movement, the codydramol was substituted three days later for oral morphine again, now in a modified release preparation (MST) in a dose of 20mg/24h, subsequently increased to 40mg/24h. Mrs Spurgin's hip wound began to leak large amounts of serous fluid and blood. This initially improved with steristrips but on the 7th April 1999 it was red and inflamed and antibiotics (metronidazole and ciprofloxaxin) commenced. Although the use of antibiotics was appropriate for a possible wound infection, it was not, in my experience, a typical combination used for a post-operative wound infection. Dr Reid reviewed Mrs Spurgin and found that movement of the right leg was still painful. It was now 18 days after Mrs Spurgin's operation and a progressive improvement in pain and mobility can generally be anticipated. This was not the case for Mrs Spurgin and Dr Reid was concerned enough to ask for an X-Ray and it should be confirmed if this was undertaken or not and, if so, the result found. However, an orthopaedic assessment was not sought. Because Mrs Spurgin was 'apprehensive' Dr Reid commenced flupenthixol 0.5mg twice a day. I am unfamiliar with the use of flupenthixol (an antipsychotic) for managing anxiety in the elderly.

The pain on movement did not improve although Mrs Spurgin denied pain when left alone. Mrs Spurgin became less well; she spilt drinks and had a nightmare. She was noted to be very drowsy – unrousable at times, irritable, leaning to the left and experiencing difficulty in swallowing. The wound was inflamed, hot and tender. She was catheterised but drained only small amounts of concentrated urine. The exact cause of Mrs Spurgin's deterioration is unclear as no medical assessment was undertaken. Even simple observations like temperature, heart rate and blood pressure were not carried

out. However, in my opinion, her situation could be consistent with septicaemia from an infection despite her current antibiotics ± cummulation of morphine metabolites as she became dehydrated. Even in her statement, Dr Barton anticipates that Mrs Spurgin's drowsiness was a consequence of her infection (point 40).

On the 12th April 1999, a syringe driver was commenced containing diamorphine 80mg/24h. This is equivalent to oral morphine 160–240mg/24h and thus represents a 4–6 fold increase Mrs Spurgin's dose of morphine. There is no apparent justification for an increase of this magnitude in the dose of analgesia, and, in my opinion, was excessive to Mrs Spurgin's needs. This would explain why Dr Reid noted Mrs Spurgin to have been very drowsy since the diamorphine infusion was commenced (he states she was not rousable! (his emphasis)) and why he was able to move her hip without pain. The syringe driver also contained midazolam 20mg/24h, a dose likely to sedate a 92 year old. Given that the major risk of excessive opioid is respiratory depression, in an unrousable patient, it would have been reasonable for a doctor to have assessed respiratory function, e.g. respiratory rate and the level of oxygen saturation in the blood (pulse oximetry). If there was evidence of respiratory depression, discontinuation of the opioid and careful use of the opioid antagonist naloxone to partially reverse the effects of the opioid would have been indicated to rouse the patient and restore satisfactory ventilation. Even if naloxone was not deemed necessary, other practitioners would stop the opioid until the patient was more awake, and subsequently restart at a lower dose. Others may continue the opioid but at a lower dose. Although Dr Reid halved the diamorphine dose to 40mg/24h, this was still equivalent to oral morphine 80–120mg/24h, i.e. a 2–3 fold increase on Mrs Spurgin's previous

dose. In my opinion, given Mrs Spurgin's dose of oral morphine 40mg/24h, using a 2:1 or 3:1 conversion ratio, an appropriate starting dose of diamorphine would have been 15–20mg/24h. Further, there was a simultaneous increase in the midazolam to 40mg/24h, a dose that in my opinion would sedate a 92 year old. In this regard, despite the reduction in opioid, the increase in midazolam would have contributed to Mrs Spurgin remaining sedated until her death at 01.15h on the 13th April 1999.

The cause of death was given as a cerebrovascular accident. The clinical evidence on which this is based should be clarified. In her statement, Dr Barton suggests 'the reference to her leaning to the left raised the possibility that Mrs Spurgin might have had a cerebrovascular accident'. However, on its own, this is a non-specific finding which could occur in an elderly patient with a reduced level of consciousness due to any cause. If it were strongly considered that Mrs Spurgin had had a cerebrovascular accident, one would expect that this significant change in her clinical condition to have been recorded in the medical notes and accompanied by a medical assessment. In my opinion, the circumstances of Mrs Spurgin's deterioration and death are not typical of a cerebrovascular accident and thus there is a lack of sufficient supporting clinical evidence and certainty that a cerebrovascular accident was the most likely cause of her death.

Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

The overall care given to Mrs Spurgin whilst at Haslar Hospital has raised concerns as detailed in the report by Mr Redfern.

The medical care provided by Dr Barton and Dr Reid to Mrs Spurgin following her transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, July 1998, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

Specifically:

i) The notes relating to Mrs Spurgin's transfer to Dryad Ward are inadequate. On admission, a patient is usually clerked highlighting in particular the relevant history, examination findings, planned investigations and care plan.

ii) There was insufficient assessment and documentation of Mrs Spurgin's pain and its treatment.

iii) An orthopaedic opinion was not sought even when the pain did not improve with time or increasing doses of morphine that were associated with undesirable effects.

iv) An appropriate medical assessment was not undertaken when Mrs Spurgin deteriorated, becoming more drowsy and her wound more painful and inflamed.

v) Doses of diamorphine and midazolam that were excessive to her needs were administered.

If the care is found to be suboptimal what treatment should normally have been preferred in this case?

In relation to the above:

Issue i (lack of clear documentation that an adequate assessment has taken place)

A medical assessment usually consists of information obtained from the patient or others and existing medical records (the history), and the findings of a physical examination that is documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. a basic physical examination, etc.

Clerking of a patient also provides a baseline for future comparison. If new problems subsequently develop, and abnormal physical findings are found on examination, it can be helpful for the doctor when considering the differential diagnosis and management to know if the findings are really new or old. A clear assessment and documentation of subsequent medical care are particularly useful for on-call doctors who may have to see a patient, whom they have never met, for a problem serious enough to require immediate attention.

Issue ii (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs)

Part of the plan outlined by Dr Barton was to sort out Mrs Spurgin's analgesia. Particularly when pain relief is considered such a prominent part of the care plan for a patient, it would be considered good practice to take and document a full pain history and undertake an appropriate examination. This is to help diagnose the most likely cause of the pain and thus guide a rational and appropriate management plan.

Dr Barton considered Mrs Spurgin unable to weight bear and that her pain to require regular morphine. This was in contrast to the transfer note, written on the same day of transfer, which recorded Mrs Spurgin to be mobile with help and requiring only p.r.n. 'as required' paracetamol. There is no documented history or examination which suggests that the possible reasons for this apparent increase in pain were considered. This is relevant, because, if increasing pain was associated with a wound infection for example, this would require appropriate antibiotics rather than morphine. Further, given that pain generally improves quickly and progressively in patients who have undergone surgical repair of their fractured neck of femur, the need to commence strong opioid analgesia for severe pain one week post-operatively should have been a particular prompt to have undertaken a thorough assessment.

It is unclear on what basis Dr Barton considered that regular morphine was necessary, rather than initially trying a regular weak opioid ± paracetamol. In general, practitioners progressively increase the strength of regular analgesia and the dose against the patients pain, in the order non-opioid (e.g.

paracetamol) → weak opioid (e.g. codeine) → strong opioid (e.g. morphine). Although some may omit the weak opioid step and go straight to a strong opioid, this usually involves a smaller initial dose of morphine (e.g. 20–30mg/24h). Although the starting dose of morphine and its increase prescribed by Dr Barton were in keeping with the BNF, in the context of omitting a regular weak opioid step and in view of Mrs Spurgin's advanced age, it would have been prudent in my opinion to have used a smaller dose. Mrs Spurgin's nausea and vomiting could be in keeping with the doses she received being excessive, although up to half of patients can experience nausea and vomiting when commencing morphine.

Issue iii (in providing care you must be willing to consult colleagues)

Because of Mrs Spurgin's nausea and vomiting, the morphine was discontinued and she received regular codydramol for about 3 days. However, because of persistent pain, Dr Barton recommenced a smaller dose of morphine. This was 11 days after Mrs Spurgin's operation and this level of pain and analgesic requirement should have prompted a search for the cause of the pain. In this regard there is no evidence that Dr Barton considered, examined Mrs Spurgin or documented the possible reasons why Mrs Spurgin's pain was so problematic, discussed her with Dr Reid or the orthopaedic team. Similarly, when the morphine was increased to 40mg/24h, 17 days after Mrs Spurgin's operation, neither Dr Barton nor Dr Reid contacted the orthopaedic team. An X-ray was apparently requested, but I am unable to ascertain if it was carried out.

Finally, it should be ascertained if the choice of ciprofloxacin and metronidazole for a post-operative (orthopaedic) wound infection was in

keeping with Trust guidelines, and, if not, why the advice of a microbiologist was not obtained.

Issue vi ((lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; in providing care you must be willing to consult colleagues)

Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare. When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation. There is no assessment or even simple observations documented. This is relevant, as in my opinion, Mrs Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites; even though the morphine dose had not been increased, in dehydration morphine metabolites cumulate as if the dose of morphine had been increased. Intravenous hydration, reduction in the dose of morphine and different antibiotics may well have been of benefit to Mrs Spurgin and it should be ascertained why these were not considered appropriate. Particularly the latter, as in her statement, Dr Barton's appears to consider that an infection was contributing to Mrs Spurgin's drowsiness. For patients this unwell with an infection, particularly despite the existing use of antibiotics, the choice of

further antibiotic(s) would usually be made with the help of a microbiologist and modified subsequently based on results of wound, blood and urine cultures etc. There is no documentation to suggest that Dr Barton discussed Mrs Spurgin's management with Dr Reid, the orthopaedic team or a microbiologist before commencing a syringe driver containing diamorphine and midazolam.

Issue v (lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs; willing to consult colleagues)

On the 12th April 1999, Dr Barton prescribed diamorphine 20–200mg, midazolam 20–80mg, hyoscine (hydrobromide) 200–800microgram (marked p.r.n. in the margin) and cyclizine (an anti-emetic) 50–100mg (marked p.r.n. in the margin) all SC/24h.

It is unusual that drugs to be given by syringe driver are prescribed 'as required' especially in a wide dose range. This is because of the inherent risks that would arise from a lack of clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For example, the lower dose range of diamorphine was 20mg/24h, but Mrs Spurgin was commenced on 80mg/24h. For these reasons, prescribing a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication.

If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and

indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, diazepam/midazolam and other drugs that could be given intermittently 'as required' orally or SC alongside the fixed regular dose of analgesic. This allows a patient to receive what they need, when they need it and guides the doctor in subsequent dose titration of the regular dose of analgesic.

The wide dose range of diamorphine 20mg–200mg, is not justified at all in the notes and in my opinion includes doses excessive for Mrs Spurgin's needs. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

The equivalent subcutaneous dose of diamorphine is generally calculated by dividing the oral morphine dose by 2 or 3 (see technical issues). As Mrs Spurgin had been receiving oral morphine 40mg/24h, this is approximately equivalent to diamorphine 15–20mg/24h. A syringe driver was commenced containing diamorphine 80mg/24h, equivalent to oral morphine 160–240mg/24h, representing a 4–6 fold increase in Mrs Spurgin's dose of morphine. There is no justification for an increase of this magnitude in the dose of analgesia, and, in my opinion, was excessive to Mrs Spurgin's needs. The syringe driver also contained without apparent justification, midazolam 20mg/24h, a dose likely to sedate a 92 year old. As a result, Dr Reid found her unrousable and unresponsive to movement of her hip (a painful stimulus). Given the depth of her sedation, it would have been reasonable to have assessed her respiratory function, e.g. respiratory rate and the level of oxygen saturation in the blood (pulse oximetry), but this did not occur. In my opinion the syringe driver should have been discontinued and Mrs Spurgin's condition

monitored closely for evidence of respiratory depression, pain or agitation. Other practitioners may well choose to continue the opioid but at a lower dose as Dr Reid did. However, the dose he selected, diamorphine 40mg/24h, is equivalent to oral morphine 80–120mg/24h, i.e. still a 2–3 fold increase on Mrs Spurgin's previous dose. Further, there was a simultaneous increase in the midazolam to 40mg/24h, a dose that in my opinion would sedate a 92 year old, and was unjustified given that she was already unresponsive.

In her statement, Dr Barton makes the point that even 40mg of diamorphine was not seemingly successful in relieving Mrs Spurgin's pain as she was 'in some discomfort when attended to'. This, in my view, continues to underscore the point that the pain that Mrs Spurgin was experiencing on movement was not relieved by a dose of diamorphine that was associated with undesirable effects (i.e. sedation). This is unusual for someone who had undergone repair of a fractured neck of femur with a dynamic hip screw and reinforces the point that an orthopaedic review should have been sought.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

In my view, Mrs Spurgin was not anticipated to be dying and very likely that her pain and subsequent deterioration were due to potentially reversible (and possibly preventable) causes that could be managed by the timely provision of hydration, a reduction in morphine dose and appropriate antibiotics. The pain was out of keeping with that usually seen in this situation, and failed to improve with time or increasing doses of morphine. Thus there were several prompts for both Dr Barton and Dr Reid to have sought an orthopaedic review.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to inappropriate doses of diamorphine and midazolam that would have contributed more than minimally,

negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary 36 (September 1998).

Prescribing in Terminal Care, pages 11–14

Prescribing for the elderly, pages 15-16

Good Medical Practice, General Medical Council, July 1998, pages 2–3

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

'Wessex Protocol' Salisbury Palliative Care Services May 1995.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

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STATEMENT OF DR JANE BARTON

RE: ENID SPURGIN

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Enid Spurgin. Unfortunately, at this remove of time I have no recollection at all of Mrs Spurgin. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Spurgin.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mrs Spurgin.

4. Mrs Enid Spurgin was 92 years of age and lived alone in a bungalow, together with her greyhound. I am unable to relate anything of significance in relation to her medical history, being unable to recall Mrs Spurgin at this remove of time, and only very limited previous medical records have been made available to me. From the documentation which has been produced, it appears that in November 1997 she was referred to a Consultant in Elderly Mental Health, seemingly suffering with depression. The Consultant, Dr Mears, carried out a domiciliary visit and reported that Mrs Spurgin had lost interest in the things she previously enjoyed. She had fleeting suicidal ideas, and she described Mrs Spurgin's mood as depressed and hopeless. Dr Mears diagnosed that Mrs Spurgin was suffering from a depressive illness relating to failing physical health and her loss of independence. Mrs Spurgin had been taking Domperidone, and prior to that Prothiaden, but Dr Mears decided that she should try a very small dose of Citalopram. She planned to arrange for the Community Psychiatric Nurse to call to offer support and counselling.

5. Consequent on that assessment Dr Mears then wrote to the Community Psychiatric Nurse on 12th November 1997 asking her to call in to see Mrs Spurgin saying that she had become depressed over the last couple of months, that her physical health was failing and she was losing her independence. The Community Psychiatric Nurse (CPN) duly saw Mrs Spurgin and reported to Dr Mears the following January that poor short-term memory appeared to be her primary problem, and her main concern was poor eyesight and her consequent loss of independence.

6. It appears that she reported a number of falls in the course of 1998 due to her dog pulling her over.

7. Mrs Spurgin was also referred in turn by the CPN to Occupational Therapy for help aids to daily living. A number of suggestions were made to her including a bubble bath which Mrs Spurgin compared to "having a bath with a cobra". Other modifications were, apparently more helpful, including grab rails and a Bath Knight. She was discharged from CPN follow-up, apparently in good spirits, in January 1999.

8. On 19th March 1999 Mrs Spurgin fell and fractured her right leg femur. She was admitted to the Royal Hospital at Haslar, and the following day had a dynamic hip screw inserted. By 26th March it appears that she was considered well enough to be transferred to Dryad Ward at the GWM Hospital for rehabilitation, although I do not know anything of the circumstances in which she came to be admitted, in the absence of medical records in that regard.

9. The nursing note accompanying Mrs Spurgin on her transfer to the GWMH suggested that she was mobile from bed to chair with the assistance of 2 people and could walk short distances with a Zimmer frame. She was said to have no urinary symptoms, but despite being continent during the day she was sometimes incontinent at night. Her skin was described as "paper thin" and so no TED stockings had been given to her following the operation. Her right lower leg was very swollen and had a small break on the posterior aspect. She apparently needed encouragement with eating and drinking but could manage independently. Her only medication at that time was Paracetamol as required.

10. I admitted Mrs Spurgin to Dryad Ward, and my note in this regard in her record reads as follows :-

"26-3-99 Transfer to Dryad Ward

HPC # no femur ®19-3-99

PMH - nil of significance

Barthel xxxxx

not weight bearing

tissue paper skin

not continent

Plan sort out analgesia"

11. Mrs Spurgin had been discharged from the Royal Hospital Haslar relatively shortly after her fracture and operation and I believe we were concerned to reassess her wound and ensure that she should have adequate analgesia, anticipating that she would be in pain. A Nursing Care Plan for 26th March 1999 records that swabs were to be taken, with MRSA screening, and steps taken by the nursing staff to prevent infection. Resulting reports confirm that swabs were taken that day from the nose, throat, groin and wound, all being negative for MRSA. I also authorised blood tests.

12. A nursing entry for 26th March recorded that Mrs Spurgin was experiencing a lot of pain on movement. Her named nurse, Lyn Barrett, also noted that Mrs Spurgin was experiencing a lot of pain on movement. She advised giving prescribed analgesia and monitoring the effect. Concerned to ensure that she had adequate pain relief, I prescribed Oramorph in a 10 mg/5ml solution, 2.5mls 4 hourly, with a further 5mls at night. I also wrote up a further PRN prescription for Oramorph to

be given as necessary - representing a further 2.5/5 mls 4 hourly as required. As Oramorph might bring about constipation, I prescribed Lactulose, 10mls twice a day.

13. The nursing records for 26th March record that Mrs Spurgin was admitted for rehabilitation and gentle mobilisation, and that in Haslar she was mobile with a Zimmer frame and two nurses for short distances, the transfer apparently being satisfactory. It was noted, however, that transfer had been difficult since admission, and that she was complaining of a lot of pain for which she was receiving Oramorph regularly with effect.

14. The nursing staff confirmed that Mrs Spurgin's skin was very fragile and a Waterlow pressure sore score produced a figure of 32, a figure of 20 or more indicating very high risk. In consequence, Mrs Spurgin had a Pegasus B-wave mattress in an attempt to prevent the development of pressure sores.

15. Following my prescription, Mrs Spurgin did indeed receive Oramorph on 26th March, 2 doses of 5mgs followed by a further 10mgs that night. The nursing entry for the night of 26th March records that she required much assistance with mobility due to pain/discomfort. A further 5mgs Oramorph was then given early the following morning.

16. The following day, 27th March was a Saturday, but I believe that I was on duty that weekend and would have visited the ward on the Saturday morning, and would therefore have assessed Mrs Spurgin's condition although I did not have an opportunity to make an entry in her records. Her nursing entry record for 27th March noted that Mrs Spurgin was having regular Oramorph but was still in pain. I anticipate that when I

assessed her on the morning of 27th I was concerned that the Oramorph previously administered had not been adequate in relieving pain, and the drug chart shows that I increased the prescription accordingly, prescribing 10mls of Oramorph to be given 4 times a day, with a further 20mls at night. With 5mgs having been given at about 6.00 am, a further 20 mgs were given in the course of the day. It was not considered necessary to administer Oramorph at 6.00 pm, but the 20mg dose was then given at 10.00 pm, representing a total of 45mgs that day.

17. Further Oramorph was then given the following day, 28th March, with 2 lots of 10mgs being administered in the morning as prescribed, but thereafter it was discontinued. The nursing entry records that Mrs Spurgin had been vomiting with the Oramorph and that I advised that it should be stopped. I anticipate that I was contacted by the nursing staff, being on duty that weekend, and I advised that in view of the vomiting the Oramorph should be discontinued. I asked that Mrs Spurgin should be given 2 tablets of Co-Dydramol 4 times a day, together with Metoclopramide 10mgs, to be given as required. Both drugs are written up on the drug chart as having been authorised by me, and I subsequently endorsed the prescriptions with my signature.

18. I would then have reviewed Mrs Spurgin again the following morning, Monday 29th March and I anticipate I hoped that the Co-Dydramol might be successful in relieving the pain at that time. The nursing records show that Mrs Spurgin's wounds were re-dressed, and further swabs were taken from the wound site and from the axilla to test once more for MRSA and other infection. There is an entry in the Nursing Care Plan signed by Lyn Barrett requesting further swabs in this regard. The swabs were subsequently reported as being negative for infection.

19. I also prescribed Senna tablets on 29th March for constipation.

20. Dr Ian Reid, Consultant Geriatrician, under whose care Mrs Spurgin had been admitted, would generally carry out a weekly ward round, but there is no entry recorded for the week commencing 29th March and I am unable now to say if he saw Mrs Spurgin in the course of that week. I would, however, have reviewed Mrs Spurgin again the following day, 30th March. The nursing staff noted that her wounds were re-dressed, Mrs Spurgin having a wound on her calf in addition to the wound on her hip at the site of operation. One wound was said to be oozing slightly.

21. Unfortunately, the Co-Dydramol appears to have been inadequate in relieving Mrs Spurgin's pain. I believe I would have reviewed Mrs Spurgin again on 31st March, and there is an entry on the drug chart recording a prescription by me for 10mgs of Morphine Sulphate to be given twice a day. The first dose was administered at 9.30 am that morning, and I anticipate this would have been in consequence of inadequate pain relief from the Co-Dydramol, although again I did not have an opportunity to make a specific entry in Mrs Spurgin's records. The nursing notes, however, record the fact that she was commenced on 10mgs of Morphine Sulphate twice a day, and that when she walked with the Physiotherapist she was in a lot of pain. It appears that in addition to the Morphine Sulphate given that day, 5mg Oramorph was given at 1.15 pm for pain, that being available through my original PRN prescription, but apparently with not much effect.

22. A further 10mgs of Morphine was given at 8.00 pm in accordance with my prescription.

23. On 31st March her wounds were re-dressed once more, and there is reference in the nursing notes to a wound on her ankle, reflecting the fact that her skin was indeed very fragile.

24. Unfortunately, the Morphine Sulphate appears to have been unsuccessful in alleviating Mrs Spurgin's pain entirely. The nursing record indicates that she was still having pain on movement the following day, 1st April.

25. The following day, 2nd April Mrs Spurgin was now noted as having a small wound on her arm. She continued to have Morphine Sulphate, 10mgs twice a day, but on 3rd April it was again noted that she still continued to have pain on movement even with the Morphine Sulphate.

26. I would not have seen Mrs Spurgin over the course of the weekend 3rd/ 4th April, but anticipate that I would have reviewed her condition again on the following Monday, 5th April.

27. I saw Mrs Spurgin again the following morning, 6th April, and although I would not have had an opportunity to make a specific note in her records, I believe that as she was experiencing pain which was still not adequately controlled by the Morphine Sulphate, I was concerned to increase the dose of Morphine Sulphate to 20mgs twice a day. 10mgs had been administered at 8.00 am, but 20mgs were then given at 8.00 pm that evening.

28. I believe I was also concerned at the possibility that Mrs Spurgin was now developing an infection from her wounds. On 6th April the nursing staff noted that the wound in her right hip was oozing large amounts of serous fluid and some blood. Swabs were taken from the wound on her

calf, and staphylococcus infections were subsequently reported to us several days later.

29. On 7th April the nursing staff recorded that the fracture site was red and inflamed, and Mrs Spurgin was seen by me, with my indicating that she should be commenced on Metronidazole and Ciprofloxacin, and I anticipate that I was concerned Mrs Spurgin was developing an infection and should commence these antibiotics even in advance of the results of the swabs.

30. Dr Reid saw Mrs Spurgin the same day in the course of what I anticipate was a ward round, and noted specifically that she was still in a lot of pain and was very apprehensive. He also recorded the fact that the Morphine Sulphate had been increased to 20mgs twice a day the previous day. He advised that Flupenthixol, a minor antidepressant should be given and he wrote up a prescription for the Flupenthixol on her drug chart accordingly. He also asked that an x-ray of Mrs Spurgin's hip should be undertaken as movement was still quite painful and there appeared to be a 2 inch shortening of her right leg. I am unable now to say what the x-ray demonstrated as there is no report available in the medical records provided to me.

31. The nursing record confirms that x-ray was arranged for the following day at 3.00 pm.

32. I anticipate that I would have seen Mrs Spurgin again on 8th and 9th April, and noted that her condition remained essentially unchanged - that she was in a lot of pain as recorded by Dr Reid on 7th April in spite of the fact that she was now taking 40mgs of Morphine Sulphate a day. On 8th April it was reported by the nurses that the wound on her hip

was oozing slightly overnight and the redness of the edges of the wound was subsiding. A nursing entry on 9th April records that she was to remain in bed and rest until Dr Reid had seen the x-ray of her hip, suggesting that the x-ray was in fact undertaken.

33. On 9th April Mrs Spurgin was catheterised as she had become incontinent and was in great pain when toileted. Her urine was very concentrated, as she was not drinking. The catheter drained 500mls urine over night.

34. Unfortunately, it appears that Mrs Spurgin's condition deteriorated over the weekend of 10th/11th April. The nursing entry on 10th April records that she had a very poor night. She was said to be leaning to the left, did not appear to be as well, and was experiencing difficulty in swallowing. The reference to her leaning to the left raised the possibility that Mrs Spurgin might have had a cerebro vascular accident. The stitch line from the site of the operation was said to be inflamed and hard, with a complaint of pain from Mrs Spurgin. It appears in consequence of the pain my original PRN prescription for Oramorph was utilised, 5mgs of Oramorph being given at 7.15 am on 11th April by Night Nurse Sue Nelson.

35. An assessment of the wound the same day, 11th April, by the nursing staff indicated that the wound was not leaking, but the hip felt hot and Mrs Spurgin was complaining of tenderness all around the site. She was said to be very drowsy and irritable.

36. Unfortunately, it appears that Mrs Spurgin deteriorated in the course of the afternoon. A further nursing entry that evening records that her nephew was telephoned at about 7.10 pm as her condition had

deteriorated. She was now said to be very drowsy and unrousable at times, was refusing food and drink, and was asking to be left alone. The site around the wound in the right hip still looked red and inflamed and she felt hot. She apparently did not have pain when left alone but complained when she was moved at all. It appears that a discussion took place between Mrs Spurgin's nephew and the nursing staff, with the nephew recorded as having been anxious that she should be kept as comfortable as possible.

37. The next entry in the nursing records indicates that Mrs Spurgin was seen by me, and that she was to be commenced on a syringe driver. Although there is no date by the side of that entry, suggesting that I would have seen Mrs Spurgin on the night of Sunday 11th April, I think in fact this represents a nursing entry made the following morning, 12th April. That accords with the date of the prescription for Diamorphine and Midazolam to be administered by syringe driver which I have written up on the drugs chart for 12th April.

38. I anticipate that in the usual way I would have reviewed Mrs Spurgin on the morning of Monday 12th April, and in view of her condition and deterioration, I was concerned that Diamorphine and Midazolam should now be available to provide relief from pain and distress. I wrote up a prescription on her drugs chart for Diamorphine to be administered subcutaneously by syringe driver at a dose range of 20-200mgs, Hyoscine to be available PRN - as required - 200-800 mcgs and Midazolam to be administered at a dose range of 20-80mgs. In case of nausea I also prescribed Cyclizine, 50-100mgs to be given as required subcutaneously, together with a further prescription of Lactulose and Senna tablets in case of constipation.

39. Administration of Diamorphine and Midazolam are then recorded as having commenced by syringe driver at 9.00 am on 12th April, the Diamorphine at a dose of 80mgs, and the Midazolam at 20mgs. I anticipate that the dose of both the Diamorphine and the Midazolam would have been discussed with me. I believe I would have considered 80mgs to be appropriate at that time given the fact that the Oramorph was clearly inadequate in alleviating Mrs Spurgin's pain and distress. She had by that time been receiving 40mgs of Morphine Sulphate per day, with a further 5mgs of Oramorph day previously, and I considered this increase in medication to be a reasonable one in view of her condition at that time.

40. Dr Reid then appears to have carried out a ward round that afternoon, recording that Mrs Spurgin was now very drowsy since the Diamorphine infusion had been established - though of course there were nursing entries for 11th April, preceding the administration of the Diamorphine, which indicated that she had been very drowsy at that time, which I anticipate was in consequence of her infection. In any event, Dr Reid felt it advisable to reduce the Diamorphine infusion to 40mgs, but noted that if the pain recurred, it should be increased to 60mgs. He recorded that it was now possible to move Mrs Spurgin's hip without pain and that she was not rousable at that time.

41. The corresponding entry in the nursing records indicates that the Diamorphine was to be reduced to 40mgs, but if the pain recurred, the dose could be gradually increased as and when necessary. It was noted that Mrs Spurgin's nephew had been spoken to and was aware of the situation. I anticipate that the nursing staff were well aware by this stage that Mrs Spurgin was probably dying and would have been concerned to make her nephew aware of the position.

42. In consequence of Dr Reid's review, the nursing records show that the dose of Diamorphine in the syringe driver was discarded, with 40mgs over 24 hours being commenced at 4.40 pm. Accordingly, from the time when the Diamorphine was instituted at 9.00 am only approximately 25mgs of Diamorphine would have been administered in accordance with my initial prescription by the time of the change in dose at 4.40pm.

43. The nursing night staff recorded that on the night of 12th April Mrs Spurgin's condition "remained ill". Her urine was said to be very concentrated. The syringe driver was apparently satisfactory, though she appeared to be in some discomfort when attended to, so that even the 40mgs of Diamorphine was not seemingly successful in relieving her pain and distress entirely. Her breathing was reported as very shallow.

44. Sadly, Mrs Spurgin is recorded as having died peacefully at 1.15 am on 13th April.

45. The Diamorphine and Midazolam, and indeed the Oramorph and Morphine Sulphate which preceded them were prescribed by me and in my view administered solely with the intention of relieving the pain and distress which Mrs Spurgin was suffering. At no time was the medication provided with the intention of hastening Mrs Spurgin's demise.

Signed and dated [redacted]
15-3-05 handed to
D.C. Yat 9.43 am

Code A